

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001732

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149, County Registration District No. 1002, Registrar's No. 437

STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in 1b <b>2 months</b>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7704 EAST 110TH</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>PINK</b> Last <b>MATHIS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired feed mill worker</b>		11. BIRTHPLACE (City and state or country) <b>Marshfield, Missouri</b>	
13a. FATHER'S NAME <b>Sylvester Mathis</b>		14. NAME OF HUSBAND OR WIFE <b>Cora D. Mathis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>Yes WWI</b>		17. INFORMANT <b>Cora D. Mathis, wife</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, severe</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Atherosclerosis, generalized, severe</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. VA attended the deceased from <b>Dec. 17, 1962</b> to <b>Jan. 22, 1963</b> Death occurred at <b>12:10 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated:			
22a. SIGNATURE <b>R. H. OWINGS, M.D.</b>		22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	
22c. DATE SIGNED <b>1-22-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>	
24. FUNERAL DIRECTOR <b>E.K. George &amp; Sons, Inc., Grandview, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>1-23-63</b>	
26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
 or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
 working under my personal supervision.

Student \_\_\_\_\_  
 Signature of Student Embalmer

Signed

*[Handwritten Signature]*  
 \_\_\_\_\_  
 Licensed Embalmer No. 4911

P. O. Address

*[Handwritten Address]*  
 \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.